

STATEMENT OF CLAIMANT TO REFUND DUE A DECEASED TAXPAYER

For calendar year....., or other taxable period beginning, 20....., and ending....., 20.....

PLEASE TYPE OR PRINT

Name of decedent		Name of Claimant
Date of Death	Social Security Number	Number & Street Address
Number & Street Address (Permanent residence or domicile on the date of death)		
City/Town, State & Zip Code		City/Town, State & Zip Code

I am filing this statement as (check only one box):

- A ☐ Surviving wife or husband, claiming a refund based on a joint return.
- B ☐ Administrator or executor. Attach a court certificate showing your appointment.
- C ☐ Claimant, for the estate of the decedent, other than above. Complete Schedule A and attach a copy of the death certificate or proof of death.

Please attach requested information, complete Schedule A, if applicable and sign below.

Schedule A. (To be completed only if C above is checked.)		YES	NO
1	Did the deceased leave a will?		
2(a)	Has an administrator or executor been appointed for the estate of the decedent?		
2(b)	If "No" will one be appointed?		
If 2(a) or (b) is checked "Yes" do not file this form. The administrator or executor should file for the refund.			
3	Will you, as the claimant for the estate of the decedent, disburse the refund according to the law of the State in which the decedent was domiciled or maintained a permanent residence?		
If "No," payment of this claim will be withheld pending submission of proof of your appointment as administrator or executor or other evidence showing that you are authorized under State law to receive payment.			

4	Name of Widow or Widower	Address
5	Names of surviving children	Address
6	Name of person supporting the children	Address
7	Names of decedent's living father and mother	Address
8	Names of decedent's living brothers and sisters	Address
9	Names of the living children of the decedent's deceased children	Address

Signature and Verification

I hereby make request for refund of taxes overpaid by or in behalf of the decedent and declare under penalties of perjury, that I have examined this claim and to the best of my knowledge and belief, it is true, correct and complete.

Signature (in ink) of claimant

Date

NH DEPT OF REVENUE ADMINISTRATION
 MAIL DOCUMENT PROCESSING DIVISION
 TO: 45 CHENELL DRIVE, PO BOX 637
 CONCORD, NH 03302-0637

TDD Access: Relay NH 1-800-735-2964